LOUISVILLE METRO EMERGENCY MEDICAL SERVICES

LOUISVILLE, KENTUCKY

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Ms. Mullins,

Thank you for offering this opportunity to provide input as you seek to modernize Kentucky's Certificate of Need (CON) process. Your call for stakeholder input speaks directly to a number of critical healthcare issues that we have also been working to address here in Louisville, and we are gratified to see such progressive, patient-centered leadership coming from the state level.

We met recently with Medicaid Commissioner Lawrence Kissner, Deputy Medicaid Commissioner Neville Wise and Deputy CHFS Secretary Eric Friedlander to discuss several alternative care and transportation programs Louisville Metro EMS (LMEMS) has established over the past several years. Our goal is to improve the service we deliver to the many patients in our community who call 911 with non-emergent medical issues. We know that access – both to appropriate medical care *and* the transportation needed to reach that care – is an obstacle that some patients try to overcome by taking an ambulance to a hospital emergency room. We believe this does a disservice not only to the patient, who is receiving acute, episodic care for what may be a manageable chronic condition, but also to those patients who desperately need available emergency resources to respond to their critical illnesses or injuries and to the payers responsible for footing the bills.

In an effort to help 911 patients with non-emergent medical needs reach a more appropriate and effective level of care in the least costly manner possible, LMEMS has developed a number of alternative patient care and transport initiatives, including:

- **Low-Acuity Call Triage**
  In 2010, LMEMS launched one of the country's first nurse triage programs for non-emergent 911 calls. Using a unique computer-based triage algorithm, specially-trained nurses find alternative sources of care and transportation for patients who call 911 with non-life-threatening problems.

- **Medical Outreach**
  We're providing in-home care for residents of low-income senior living facilities in partnership with a local nurse practitioner-based house call practice. We've also established a weekly walk-in clinic at a local emergency shelter for the homeless.

- **Paramedic Patient Care Navigation**
  We've trained a group of senior-level paramedics – Paramedic Patient Care Navigators (PPCNs) – to work directly with patients who call 911 with non-emergent or chronic medical needs. We intend to investigate a potential partnership with Passport Health Plan that would allow our PPCNs to make in-home visits on a select group of patients with chronic health issues; our goal is to reduce hospital readmissions for those patients through the consistent care management and assistance.

These alternative care programs match many of your stated goals of the CON modernization process. Like you, we're seeking to provide more appropriate, lower cost care to patients by redirecting them to non-hospital resources, encouraging access to consistent primary care, broadening the spectrum of healthcare resources offered to patients, and reducing the barriers patients often encounter when seeking care. And like you, we agree that the CON process should work to encourage healthcare providers to establish these types of innovative programs and partnerships.

The CON process must be flexible enough to allow diverse participants across the healthcare continuum to work more closely together than ever before. As emergency medical services, primary care providers, social service agencies and hospitals step outside of their traditional roles and combine their efforts, regulatory process should function to promote, not hinder, their work. And there needs to be freedom – even within the confines of the safeguards provided by the CON process – to experiment with new service delivery models, perhaps through a short-term waiver process that would allow entities to operate outside their regulatory scope under the guidance and oversight of CHFS.

We also believe the state can take an active role in acknowledging and overcoming some of the non-medical obstacles our citizens face in seeking care, particularly those citizens with little or no financial resources. For example, our work to connect patients with non-emergent health issues to more appropriate sources of care often falls short because our patients lack access to transportation. While Medicaid does provide transportation free of costs through the state's broker system, scheduling requirements make it less attractive to patients convinced they need to receive care quickly.

We know we could redirect many more patients to lower cost sources of outpatient care if there were more private providers of non-medical transportation; if Medicaid transportation providers were able to schedule same-day pick-ups for non-emergent or primary care; and if state regulations would encourage EMS services that would like to operate non-medical stretcher van services to do so.

As you also correctly recognized in your call for input, payment and reimbursement mechanisms are evolving to support efforts to provide better care, but we would submit they still have a long way to go before they reflect our mission to provide appropriate and cost effective care. As it stands today, our system is built to break. Ambulance services are reimbursed only for transporting a patient to a hospital ED, regardless of whether that patient even needs acute care. There is no financial incentive to help that patient find more appropriate care elsewhere. And there is certainly no incentive to provide transportation for that patient to his/her own physician's office or an immediate care center.

Emergency Medical Services are required to select the highest-cost option for their patients in order to sustain their operations.

Nor is there incentive to provide care when possible to the patient in the home. For example, our PPCNs respond on a non-emergent basis to patients with low-acuity medical needs. These paramedics can often resolve the patient's complaint in the home without a need to transport to any outside medical facility. And while on-site the PPCNs can fulfill a number of other roles – checking to make sure the patient has access to healthy food, reviewing medications and making sure the patient is taking them as prescribed, surveying the home for safety issues, etc. This program helps keep the patient in his/her home, avoiding a costly trip to the hospital and potentially even avoiding future hospital admissions or readmissions. However, there is currently no mechanism to sustain this program financially, as there is no way to seek reimbursement for the care we provide in the home. We agree that reimbursement models need to change to incentivize alternative patient care and transportation options and to decrease overall costs to the system by encouraging patients to seek appropriate care or to avoid future need for acute care.

We've been gratified to see Kentucky take the lead in the national health care conversation, establishing our state as a place where the health of our citizens takes priority through the Medicaid expansion and the remarkable success of Kynect. And we believe Kentucky is poised to lead the way again by encouraging progressive healthcare programs and partnerships that address the wide spectrum of patient needs in our communities. LMEMS stands ready to participate fully in these new endeavors, and we are hopeful that the principles you have enumerated in your call for comments become reality for all Kentuckians.

Thank you again for this opportunity to share our comments with you, and we look forward to working with you in the future.

Sincerely,

Kristen L. Miller
Chief of Staff
Louisville Metro EMS